DEPARTMENT OF [illegible]
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. BUILDING _____ B. WING _____	C 10/06/2006

POC accept Letter sent B Thurman HFSM

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EVERGREEN MOUNTAINVIEW HEALTH	201 KOONTZ LANE CARSON CITY, NV 89701

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 9/21/06. The complaint was finalized on 10/6/06 during a follow up survey that was sent under separate cover. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00012927 alleged that the facility failed to: 1. Provide enough staff to properly care for the residents - unsubstantiated. 2. Provide enough staff to accommodate the needs of the residents in a dining room - substantiated with federal deficiencies cited. See Tags F 246 and F 325. 2. Send a resident's personal belongings when discharged - substantiated with no federal deficiencies cited. 3. Prevent an avoidable fall in one resident - unsubstantiated. 4. Bathe a resident for five days and discharge the resident in a clean condition - unsubstantiated. The following regulatory deficiencies were identified:	F 000	**DISCLAIMER CLAUSE** PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 246	483.15(e)(1) ACCOMODATION OF NEEDS	F 246		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	RON PETERSEN ADMINISTRATOR	10-31-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

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F 246 SS=D	Continued From page 1 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined that the facility failed to accommodate the individual needs for 3 of 17 residents in the dining room of the secure unit. (Residents #1, #2, and #3) Findings include: On 9/21/06, at 8:15 AM, a general observation was made of the dining area in the secure unit on Station #2. Seventeen residents were observed in the dining room at that time. Three employees were assisting the residents eat. One of the staff members on the secure unit was interviewed. She stated that three of the residents were able to feed themselves independently. The rest of the residents needed either cueing by the staff or physical assistance with their meals. A staff member stated that three trays were not delivered to three residents. A staff member had to go and get the trays. She stated that normally two employees assisted up to 29 residents with their meals. She stated on occasion three employees would assist the residents with their meals. Resident #1: The resident was admitted to the facility on 5/8/03 and readmitted on 11/11/05.	F 246	**F246** **Actions taken for the residents cited:** Resident #1 has been reassessed by the dietitian and the MD has been made aware of the recommendations. The MD orders are being followed. The resident is receiving her meals in a timely manner and staff is assisting her as she will allow. Residents #2 and #3 are being assisted with their meals as they will allow. The timing of administering the Resource nutritional supplement will be reviewed. **How other potential residents are identified:** All residents needing assistance have the potential to be at risk. **Measures/systemic changes to ensure deficient practices do not reoccur:** The staff will be educated on timing for meal assistance. The meal pass times will be reviewed, meals will be given timely and residents will be assisted timely. **How the facility will monitor corrective actions:** The Executive Director or designee will perform random audits weekly in each dining room to ensure that the residents receive the necessary assistance for meals.	OK 11-4-06

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F 246	Continued From page 2 The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was observed attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was still attempting to eat. After she put her fork down she was asked if she wanted anymore. The resident replied that she was not done yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, the resident was asked, "Are you done?" The resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident eat. On 10/5/06, a breakfast dining observation of Resident #1 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:40 AM. At 7:55 AM, two staff members were helping two other residents eat while Resident #1 sat in front of her food without eating. A third staff member left to get a resident some sausage. At 8:15 AM, Resident #1 was observed sitting in front of her food and not eating. Her meal monitor flow sheet revealed that between 10/1/06 and 10/5/06 she had refused breakfast twice, and	F 246		

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F 246	Continued From page 3 had between 5 and 20 percent of her breakfast the other days. She had between 50 and 75 percent of her lunch between those days. She refused one dinner, one day was left blank, and two days were recorded at 5 percent taken for that time frame. Her October weight was recorded as 85 pounds. She weighed 88 pounds in September. The resident's chart was reviewed. There was no evidence of any further interventions since the observations made on 9/21/06. An observation of a medication pass on 10/5/06 at 7:30 AM revealed that the resident was administered 120 cc's (240 calories) of the supplement instead of 60 cc's as ordered. The LPN administering the Resource stated that Resident #1 had not been eating well so the staff was giving the patient 120 cc's of Resource instead of the ordered 60 cc." Review of the nutritional content of Resource 2.0 revealed that it supplied two calories per cc. The caloric distribution was 18% protein, 43% carbohydrate, and 39% fat. Resident #1 would have been provided 120 calories with the supplement twice a day if administered as ordered. A review of the record revealed that 60 cc's of Resource 2.0 was ordered with the medication pass. Resident #1 received the Resource before her breakfast meal with her morning medication. The Resource was given to the resident at 7:30 AM. The resident was served breakfast at approximately 7:40 AM. There was no evidence found indicating that the facility had attempted to give the Resource at times not so near her breakfast meal. The most recent quarterly nutritional notes signed	F 246		

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F 246	Continued From page 4	F 246		

by the registered dietician on 8/21/06, revealed that Resident's #1 was able to feed herself independently. It also revealed that she was on 60 cc's of Resource twice a day and took 100% of it. She noted that the resident's food intake was between 5 to 30% for breakfast and 10 to 20% for lunch. There was no evidence found in the record that the resident's ability to feed herself was reevaluated or that an attempt to alter the time frames of the Resource was made to see if the resident would eat more of her meals.

Review of the careplan for Resident #1 revealed that it was reviewed on 8/21/06 by the registered dietician. There were no dates next to the approaches to indicate new interventions were attempted to solve the recent weight loss issue. Cross reference Tag F 325.

The dietician stated that no one had reported to her that the resident was receiving double the Resource in order to make the appropriate dietary calculations for Resident #1.

Resident #2: The resident was admitted on 3/14/03. The resident's diagnoses included bladder disorder, dementia, esophageal reflux, and osteoporosis. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the secured unit dining area on Station #2. The resident was observed attempting to drink her hot cereal and applesauce but nothing went into her mouth. She then resorted to eating some eggs with her fingers. She then stopped and her food sat in front of her. At 8:35 AM, she found her spoon and had a few spoonfuls of eggs. When this was observed no one helped redirect the resident to her utensils so that she could eat her hot cereal and applesauce. When her tray was

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F 246	Continued From page 5 taken away approximately 75% of her food remained on her plate. She did finish her milk. Review of the dietician's nutritional notes, dated 9/7/06, revealed that Resident #2 was able to feed herself with a one person assist. During the observed meal time there was no one who physically assisted Resident #1 with her meal or redirected her to use her utensils when she attempted to drink her hot cereal and applesauce but was unable to do so. Resident #3: The resident was admitted on 3/7/02. The resident was readmitted on 1/7/05. The resident's diagnoses included profound mental retardation, convulsions, and cerebral palsy. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the secured unit dining area on Station #2. The resident's diet order revealed that he was on a pureed drinkable honey thick diet. He was observed eating his meal with his fingers. His face was full of food as well as his chest area, and there was orange colored liquid spilled on the floor near him. A staff member stated that he got mad when staff tried to help him eat. She also stated that he had not spilled food all over the floor like he normally does. Based on this information it would be difficult to obtain accurate measurements of the resident's food intake. A review of the record revealed that on 12/30/05 Resident #3 was able to eat a cup of food with a spoon. After that time there were notes that the resident ate by himself but there was no indication on how he was eating his food. There was no recent evaluation by occupational therapy to see if he was still able to eat with a spoon.	F 246		

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F 246	Continued From page 6 On 9/21/06, at approximately 10:40 AM, the speech therapist was interviewed. She stated that Resident #3 was unable to advance to finger foods. She was asked if occupational therapy (OT) had conducted a recent evaluation to see if he would be able to use utensils since it was documented that he was able to use a spoon on 12/30/05. She stated that a current evaluation had not been conducted and that she would speak with the resident's nurse about obtaining an order for a OT evaluation. On 9/21/06, at approximately 12:30 PM, delayed trays were also observed in the main dining area near the facility entrance. There were four residents observed waiting for their trays while other residents sitting at their tables were eating their lunches. On 9/21/06, at approximately 12:50 PM, the above was discussed with the director of nursing (DON) and the administrator. It was stated that the reason not all of the residents were receiving their trays in a timely manner was due to a new staff member in training in the kitchen that was having difficulty meeting the need to get trays out in a timely manner. The issue was identified and being addressed. The individual observations for each resident were discussed with the DON. It was determined that the resident's needs needed to be reevaluated. The DON stated that the nurses were instructed to help residents eat along with the nurse aides. During the meal observation the nurse assigned to the locked unit was busy administering medications to the residents. After the initiation of the meal observation the staff development nurse later came in to help.	F 246		

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F 246	Continued From page 7 On 10/5/06, a general observation was made of the Station #2 dining room. Three staff members were assisting 22 residents. The first meal cart arrived at 7:10 AM. Two residents were given trays from this cart. They were each sitting at different tables and eating while their table mates watched them. One of the staff members stated that a new staff member had passed out the trays because she was new and was unaware that she was supposed to wait until all the resident received their trays. Three trays were left on the first cart. A second cart of trays arrived at 7:40 AM. The three trays that had been sitting around for half an hour were then distributed to the residents. At 7:55 AM two staff members were assisting residents with their meals. Four other residents that required assistance were waiting with their food in front of them. At 8:15 AM, the last resident requiring assistance was assisted; her tray had come off the first cart. From the time the first cart arrived at 7:10 AM to the time the last resident was assisted with her food 55 minutes had passed.	F 246		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review and observation it was determined that the facility failed to monitor,	F 325	**F325** **Actions taken for the residents cited:** Resident #1 had a significant weight loss between her readmission in November 2005 and February 2006. Since then she has stabilized and gained some weight as indicated by the history in the deficiency. The care plan has been updated to reflect her current needs. **How other potential residents are identified:** All residents needing assistance, who have dementia, residents needing assistance or sudden illness have the potential to be affected.	

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F 325	Continued From page 8 re-evaluate and prevent weight loss for 1 of 17 residents. (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 5/8/03 and readmitted on 11/11/05. The resident's diagnoses included dysphagia, hypertension, senile dementia, iron deficiency anemia and venous insufficiency. On 9/21/06, at 8:15 AM, a breakfast meal observation was made in the dining area of the secure unit Station #2. The resident had a mechanical soft, vegetarian meal. The resident appeared to be asleep in her chair and not eating her meal. At 8:35 AM, she was awakened and asked "are you done?" The resident replied just about and started drinking her milk. A staff member came in to the dining area and asked about the resident. One of the employees assisting the residents across the room stated that the resident had Resource before her meals and did not eat her meals. She stated that the Resource was good enough. At 8:40 AM, the resident was observed attempting to eat her eggs with a fork but having difficulty. At 8:45 AM, the resident was still attempting to eat. After she put her fork down she was asked if she wanted anymore. The resident replied that she was not done yet. At 8:50 AM, she was still working on her milk. At 9:50 AM, the resident was asked, "Are you done?" The resident replied, "I guess so" and her tray was taken away. There was no physical attempt made to help the resident eat. On 10/5/06, a breakfast dining observation of Resident #1 was made in the Station #2 dining room. The cart with the resident's tray arrived at 7:40 AM. At 7:55 AM, two staff members were	F 325	**Measures/systemic changes to ensure deficient practices do not reoccur:** The staff will be educated on dietary needs and care plan updates. This will include any new information discovered with the resource protocol. Residents with weight loss will be reassessed by the dietitian. **How the facility will monitor corrective actions:** The facility will conduct a weekly meeting to review residents that have had weight loss. The care plans will be reviewed and revised at this meeting. The results of these meetings will be reviewed by the monthly QI meetings.	11-4-8

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F 325	Continued From page 9	F 325		

helping two other residents eat while Resident #1 sat in front of her food without eating. A third staff member left to get a resident some sausage. At 8:15 AM, Resident #1 was observed sitting in front of her food and not eating. Her meal monitor flow sheet revealed that between 10/1/06 and 10/5/06 she had refused breakfast twice, and had between 5 and 20 percent of her breakfast the other days. She had between 50 and 75 percent of her lunch between those days. She refused one dinner, one day was left blank, and two days were recorded at 5 percent taken for that time frame. Her October 2006 weight was recorded as 85 pounds. She weighed 88 pounds in September 2006. The resident's chart was reviewed. There was no evidence of any further interventions since the observations made on 9/21/06.

A review of the record revealed that Resource was ordered with the medication pass. Resident #1 received the Resource before her breakfast meal. There was no evidence found to indicate that the facility had attempted to give the Resource at times other than before breakfast. The Resource was given to the resident at 7:30 AM. The resident was served breakfast at approximately 7:40 AM.

An observation of a medication pass on 10/5/06 at 7:30 AM revealed that Resident #1 was administered 120 cc's (240 calories) of the supplement instead of 60 cc's as ordered. The LPN administering the Resource stated that Resident #1 had not been eating well so the staff was giving the patient 120 cc's of Resource instead of the ordered 60 cc's." Review of the nutritional content of Resource 2.0 revealed that it supplied two calories per cc. The caloric

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F 325	Continued From page 10 distribution was 18% protein, 43% carbohydrate, and 39% fat. Resident #1 would have been provided 120 calories with the supplement twice a day if administered as ordered. The most recent quarterly nutritional notes signed by the registered dietician on 8/21/06, revealed that Resident #1 was able to independently feed herself. It also revealed that she was on the Resource twice a day and took 100% of it. She noted that the resident's food intake was 25% for breakfast, lunch and dinner. There was no evidence found in the record that the resident's ability to feed herself was reevaluated or that an attempt to alter the time frames of the Resource was made to see if the resident would eat more of her meals. A review of the weight record revealed that Resident #1's weight history was: 100 pounds on 11/11/05 92 pounds on 12/1/05 90 pounds on 1/4/06 83 pounds on 2/1/06 85 pounds on 3/3/06 84 pounds on 4/4/06 87 pounds on 8/7/06 88 pounds on 9/6/06. 85 pounds in October 2006 The alteration in nutrition care plan was dated 11/15/05. Although the careplan was reviewed on 8/21/06 by the registered dietician there were no dates next to the approaches showing that new interventions were attempted to solve the weight loss issue. The dietician stated that no one had reported to	F 325		

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F 325	Continued From page 11 her that the resident was receiving double the Resource in order to make the appropriate dietary calculations for Resident #1.	F 325		